Joint & Muscle Research Institute

Authorization to Use or Disclose Health Information

Name: _____ Date of birth: _____

I authorize the use or disclosure of the above name individual's health information as described above.

The type of information to be used or disclosed is as follows (check all that apply)

_____Clinical Notes
_____Radiology Notes
_____Progress Notes
_____Laboratory Reports
_____History & Physical Report
_____Prescription History
_____Consultation Notes
_____Other

I understand that the information in my health records may include information relating to sexually transmitted, diseases, HIV/AIDS, behavioral or mental health, treatment for alcohol or drug abuse.

The information identified above may be used or disclosed to the following individual(s) or organizations:

Joint and Muscle Research Institute
Dr. Alireza Nami and Dr. John Brendese
332 Lillington Ave.
Charlotte NC 28204

I understand that I have the right to revoke this authorization at anytime. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation may not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that once above information is disclosed, it may be re-disclosed by the recipient, and the information may not be protected by federal laws or regulations.

I understand use or disclosure of the information identified above is voluntary, I need not sign this form to ensure access to medical treatment.

This authorization will expire on 12 (twelve) months from the date of signature.

_____ _____
Signature of Patient or Legal Representative Date

If signed by legal representative, relationship to patient: _____

_____ _____
Signature of witness Date

Please fax records to 704-780-4284
Phone: 704-248-8577